DEPENDENT CARE REIMBURSEMENT CLAIM

1. Please PRINT or TYPE.
2. Attach bill, receipt, invoice, or complete "Provider Information" section.
3. Sign, date, and return.

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

DCAP **DEPENDENT CARE ASSISTANCE PROGRAM**

If you have any questions, please call DCAP in the Olympia area at (360) 664-7005, or toll free at 1-800-423-1524 Voice/TT.

Name _____ SSN ___ ___
☐ (Change) Last First M.I.

Address _____ Work Phone ( ) _____
☐ (Change) Number Street

_____ Home Phone ( ) _____
City State Zip

EXPENSES INCURRED (See separate Reimbursement Claim form instructions)

Date of Birth	Dependent Name (Last, First, M.I.)	From Month/Day/Year	To Month/Day/Year	Amount
- -		- -	- -	
- -		- -	- -	
- -		- -	- -	
- -		- -	- -	
- -		- -	- -	
- -		- -	- -	

PROVIDER INFORMATION (Required only if you are not submitting a bill, receipt, or invoice.)

Name

Address	City	State	Zip

I certify that I provided the dependent care services indicated on this form.

X _____ _____
Provider Signature Date

I REPRESENT THAT:

- Each dependent listed above will qualify as a dependent on my federal income tax return for the current year. (If not, I have attached a statement of explanation.) These expenses are not for kindergarten or above.
- These expenses were necessary to allow me to work, and if married, to allow my spouse to work or to be a full-time student.
- My provider is not a dependent of mine and if my provider is a child of mine, that child will be at least age 19 as of the close of the current year.
- The expenses claimed above are eligible for reimbursement under the Dependent Care Assistance Salary Reduction Program and neither I, nor my spouse, nor my dependents have received reimbursement for these claimed expenses from this Dependent Care Program or another source.
- I understand any claim for which I am reimbursed cannot also be used for federal child and dependent care income tax credit purposes.

X _____ _____ ☐ Please Send Reimbursement Forms
SIGNATURE OF EMPLOYEE DATE

Use this address on your return envelope.

DEPARTMENT OF RETIREMENT SYSTEMS
DEPENDENT CARE ASSISTANCE PROGRAM
6835 CAPITOL BLVD
PO BOX 40931
OLYMPIA WA 98504-0931

FOR DCAP USE ONLY

To	From	Approved Expenses

Revised 09/02

DCAP **Dependent Care Assistance Program**

State of Washington
Department of Retirement Systems

Reimbursement Claim Form Instructions

Please complete the DCAP Reimbursement Claim form by following these instructions.

Top Section:

Please complete your personal information. Use your legal name and home mailing address.

Expenses Incurred:

For purposes of DCAP, the term "incurred expenses" means dependent care expenses for services that have already been provided. You may submit claims at any time. The DCAP system will reimburse you after the expense has been incurred.

To expedite reimbursement processing, monthly claims may be submitted for a shorter period of time.

For example:

You have a $500.00 claim for the month of August 2003:

EXPENSES INCURRED (See separate Reimbursement Claim form instructions)				
Date of Birth	Dependent Name (Last, First, M.I.)	From Month/Day/Year	To Month/Day/Year	Amount
10 - 15 - 98	Smith, Betsy A	08 - 01 - 03	08- 15 - 03	$250.00
- -		08 - 16 - 03	08- 31 - 03	$250.00
- -		- -	- -	

- On the first line, fill in half the claim for the first half of the month.
- On the second line, fill in the claim for the second half of the month.

This will allow a portion of the claim to be processed on the first available pay date following the 15th rather than holding the entire claim until the end of the month.

Provider Information:

If you are not submitting a bill, receipt or invoice with your Reimbursement Claim form, the provider must complete this section.

I Represent That:

Sign, date and return the Reimbursement Claim form to the address at the bottom of the form.

Payments will be issued to you on Tuesdays when you submit eligible expenses approved for payment. In order to be reimbursed in the same week, you must have at least $25 in your account by Tuesday. Any unreimbursed portion of your claim will be paid from subsequent contributions as your account balance allows.

WEEKLY SCHEDULE
Monday – Reimbursement Claim form receipt cut-off
Tuesday – Payments are issued
Wednesday – Payments are mailed
Holidays or unforeseen circumstances may vary the schedule slightly.

For questions regarding reimbursement, contact Katie Buck at (360) 664-7005 or toll free at 1-800-423-1524.

Revised 09/02